University Health Services (UHS) Notice and Consent Form-Occupational Medicine Services

Acknowledgment Receipt
By signing this form, I acknowledge that University Health Services has given me notice and provided me access to the Notice of Privacy Practices.

Limits of Confidentiality and Notice to UW-Madison Employees Regarding Release of Health Information Related to UW-Madison Workplace Surveillance and Work-Related Injuries or Illness

UHS takes its commitment to confidentiality very seriously. Confidentiality means that, in general, information contained within your records cannot be disclosed without your consent. However, there are certain exceptions under federal or state laws when medical records may be shared or released without your consent, such as for OSHA compliance program requirements and other purposes described below:

- UHS will disclose to designated UW-Madison supervisory staff or safety coordinator staff responsible for occupational health and safety, identifiable health information when such information is required for UW-Madison to meet its legal requirement regarding occupational health and safety. Examples of such services include Hepatitis B immunity status, medical examinations for workers exposed to asbestos, carcinogens, lead, hazardous waste, pesticides, or other hazardous chemicals and respirator examinations.
- Records related to an injury or illness covered under Worker’s Compensation may be released to the State of Wisconsin, University of Wisconsin System, Office of Safety and Loss Prevention, Worker’s Compensation Department, or its designated representatives, at 780 Regent Street #145, Madison, WI 53715-2635. Other exceptions are explained in the Notice of Privacy Practices.
- Records for patients who are UW-Madison students may be released to other UW-Madison campus officials under the Family Educational Records Protection Act (FERPA) (e.g., when those individuals have a legitimate educational interest in knowing the information or for health or safety emergencies). Examples include communicating compliance with respirator clearance or fit testing requirements so an instructor can be assured a student has the necessary equipment to protect against classroom-related hazards.

Authorization Required for Release of Health Information to UW-Madison supervisory staff or safety coordinator staff. In addition to the workplace medical surveillance and work-related injury and illness services described above which are related to compliance with state and federal law, UHS can provide other occupational health and safety services to UW-Madison employees such as those related to animal contact. If you receive such services here, we are required to obtain your written authorization before we can provide your health information related to these services to the UW-Madison supervisory staff, safety coordinator staff, PI, director, (or designee) or your class instructor if you are a student. You will be provided with a separate Authorization for Release of Occupational Health Records form to complete for this purpose.

If you do not authorize UHS to release your health information related to the service to the UW-Madison supervisory or safety coordinator staff responsible for occupational health and safety, UHS will not be able to communicate compliance with workplace or classroom health and safety requirements to your
supervisor or instructor. Release of this information is required to ensure compliance with recommended and required health screenings and preventative services, make required workplace accommodations, and for accident and exposure investigation and follow-up.

**Consent for Medical Treatment**

I voluntarily consent to receive Occupational Health services. I understand some of these services are required by campus policy while others are voluntary. For patients in designated surveillance groups this may include review of Animal Contact Risk Questionnaires, Respiratory Risk Questionnaires, or other risk assessments. This may include immunizations, physical assessments and diagnosis, radiology and laboratory procedures, medication administration or prescription, and completion of worker’s compensation or occupational health reports by UHS Occupational Medicine healthcare providers and designated staff. I acknowledge that no guarantees have been made as to the result of treatments or examination at UHS.

**Patient Rights and Responsibilities**
As a patient at UHS, I understand that I have certain rights and responsibilities. I understand that a copy of the UHS patient rights is available from any UHS staff member or at [www.uhs.wisc.edu](http://www.uhs.wisc.edu).

**Contact Information**
I understand the following:
- To protect confidentiality, it is UHS’ normal practice to communicate personal health information with patients through their MyUHS account about health matters, such as the results of a lab test. Communication exceptions include e-mail use for appointment and reminders to complete Occupational Health questionnaires or forms.
- UHS may leave messages on my voicemail.
- I have the right to request that UHS communicate with me in a different way, and UHS will agree to reasonable requests.
- UHS will communicate minimal necessary information regarding my compliance with occupational health surveillance services to supervisor(s), safety coordinator staff, PI, director, (or designee) or class instructors via email, phone and/or a shared file site that is restricted to supervisors and safety coordinator staff.

**Certification**
By signing this form or clicking the “I consent” box, I certify that:
- I have read this form or it has been read to me, and I am satisfied that I understand its contents.
- My questions have been answered to my satisfaction.
- I acknowledge that UHS has provided me access to the Notice of Privacy Practices (located on the UHS website or a paper copy).
- I consent to communicate with my UHS provider through MyUHS and my wisc.edu e-mail.
- I consent to occupational health related treatment at UHS.

PRINT YOUR NAME _________________________ DATE SIGNED ________________

SIGNATURE _________________________ DATE OF BIRTH ________________

YOU WILL BE PROVIDED WITH A SIGNED COPY OF THIS FORM OR NOTICE UPON REQUEST. PLEASE CONTACT THE UHS HIM PRIVACY MANAGER IF YOU HAVE QUESTIONS. (608) 262-7471

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